TEXAS DEPARTMENT OF INSURANCE
Division of Workers' Compensation - Medical Fee Dispute Resolution (MS-48)
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MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name
EAST EL PASO PHYSICIANS MEDICAL CENTER

MFDR Tracking Number
M4-14-1800-01

MFDR Date Received
February 18, 2014

Respondent Name
STATE OFFICE OF RISK MANAGEMENT

Carrier's Austin Representative
Box Number 45

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "The Hospital's records reflect that the MRI was approved by Laurie Hawthorn of State Office of Risk Management. Further, Ms. Hawthorne did not stare that preauthorization was necessary. Subsequently, the Hospital's bill was denied for their alleged failure to obtain preauthorization... I am requesting that State Office of Risk Management reconsider its denial and issue payment."

Amount in Dispute: $ 1,471.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "The Office performed a in-depth review of the dispute packet submitted by the East El Paso Physician Medical Center and will main its denial for ANSI code 197- Payment denied/reduced for absence of precertification/preauthorization... The Office reviewed the claim notes to determine that the adjuster Lori Hawthorne had not given authorization for this repeat diagnostic. However, Ms. Hawthorne did speak to the injured employee on 2/26/2013 as he was checking on the status of the submitted a preauthorization request for the repeat MRI, he was advised that no preauthorization request were in the system. Further review also found that on 4/5/2013 the injured employee called the adjuster to find out the status of the repeat MRI where again he was advised that no preauthorization request was on file (Exhibit A)."

Response Submitted by: SORM

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
June 3, 2013	Rev Code 610 (CPT Code 73721-RT)	$1,471.00	$0.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all-applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §134.600 sets out the Preauthorization, Concurrent Utilization Review, and Voluntary Certification of Health Care.
3. The services in dispute were reduced/denied by the respondent with the following reason codes:

   Explanation of benefits
   - 197- Payment denied/reduced for absence of precertification/preauthorization

Issues

1. Did the disputed service, repeat diagnostic MRI require preauthorization?
2. Is the requestor entitled to reimbursement?

Findings

1. The insurance carrier denied reimbursement for the disputed MRI based upon denial reason code, "197- Payment denied/reduced for absence of precertification/preauthorization."

   28 Texas Administrative Code §134.600(p) (8) (A) states "Non-emergency health care requiring preauthorization includes: (8) unless otherwise specified in this subsection, a repeat individual diagnostic study: (A) with a reimbursement rate of greater than $350 as established in the current Medical Fee Guideline."

   The requestor submitted documentation, to support that on June 3, 2013, the requestor billed and documented CPT Code 73721-RT, defined by the AMA CPT Code Book as "Magnetic resonance (eg, proton) imaging, any joint of lower extremity; without contrast material." Further review of the requestor's documentation supports that the injured employee underwent an MRI in 2012 at the same facility. Therefore, the June 3, 2013 MRI was a repeat MRI and was subject to the preauthorization requirements of 28 Texas Administrative Code §134.600(p) (8) (A). The Division finds that the insurance carrier's denial reason code "197" is supported.
2. For the reasons indicated above, the disputed service was a repeat diagnostic and therefore required preauthorization per 28 Texas Administrative Code §134.600(p) (8) (A). The requestor submitted insufficient documentation to support that preauthorization was obtained; as a result, reimbursement cannot be recommended for the disputed CPT Code 73721-RT.

Conclusion

For the reasons stated above, the Division finds that the requestor has not established that additional reimbursement is due. As a result, the amount ordered is $0.00.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to $0.00 reimbursement for the disputed services.

Authorized Signature

Signature	Medical Fee Dispute Resolution Officer	September 3, 2015 Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute has a right to seek review of this decision in accordance with 28 Texas Administrative Code §133.307, effective May 31, 2012, *37 Texas Register 3833*, **applicable to disputes filed on or after June 1, 2012**.

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received by the Division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the Division using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.